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HB 310

Testimony for HB310
Provided by Greg Drapes, CEO
Monida Healthcare Network
February 2, 2009

Ms. Chair Arlene Becker and other members of the Human Services Committee:

My name is Greg Drapes. I am the CEO of the Monida Healthcare Network in Missoula. Monida is a not-for-profit association of seven hospitals and 500+ providers. More than 300 of these are physicians, nurse practitioners, and physician assistants. I am testifying in favor of HB310.

Monida provides a broad spectrum of professional services to our members and other clients. One of these services is peer review. A little over two years ago we were asked by the Montana Hospital Association to provide peer review services when another organization discontinued its services to Montana hospitals. We currently provide peer review to more than 30 hospitals in six states, using a panel of 60 physicians. We have limited our services to hospitals and other facilities, since the confidentiality protections offered by current statute appear to be limited to such facilities. Under the current statute, it is unclear whether medical groups are protected as "facilities" for the purposes of confidentiality of quality assurance and peer review activities. In order to encourage that quality assurance and peer review activities occur within medical groups, we wish to strongly endorse the clarification being proposed in HB310.

Concurrently, we wish to propose extending the definition of "medical groups" to include:

> "and organizations providing such services on behalf of such corporations, LLCs and partnerships" or other similar language.

The majority of our providers are in small groups. Our 500 providers are affiliated through roughly 200 separate tax ID entities. The smaller the group, the more difficult it is to provide impartial peer review. The purpose of adding this or similar language would be to allow individuals or groups of providers who are not necessarily affiliated through a single tax ID to do peer review under the same protections.

This change would also address an issue that has only recently arisen. Many hospitals have adopted hospitalist programs to provide physician coverage for their inpatients. Rather than having to balance the demands of an outpatient clinic with rounding on inpatients, as is the case with most physicians, hospitalists' practices are confined to admitting and rounding on hospital inpatients. Typically, when a hospital utilizes hospitalists, most primary care physicians refer inpatient admissions to the hospitalists. Monida follows NCQA (National Committee on Quality Assurance) guidelines for credentialing our providers. In the past, during credentialing, we have relied on the fact that peer review was being done by the hospitals for all physicians with admitting privileges to the hospital. Primary care providers who refer to hospitalists, and no longer admit inpatients, may no longer be subject to hospital peer review. We need a protected method for providing impartial peer review services for these primary care physicians.

Thank you for your time.

Medical and Surgical Peer Review

Verner S. Waite, MD, FACS, Robert Walker, JD, *Downey, California*

In medicine it is commonly found that asking 10 doctors for an opinion on medical care will result in at least 5 different suggestions. Peer review in medicine is conducted where validated guidelines often do not exist. There is still an ongoing study about tonsillectomy indications, with confusing ideas after many decades. Validated criteria are rare. With such lack of medical agreement, it is not surprising that peer review is often a contest of opinions. Unfortunately, it often has severe effects on a doctor's career. An adverse peer review is far more serious than a large malpractice award. The process has several sources for serious bias.

First, doctors on the same staff act as a jury in the case of another physician about whom they may have heard a great deal. Those bringing the charges often have enough influence within a hospital that finding against their view may be like committing professional hara-kiri. Second, the entity involved, usually the hospital or its medical staff, appoints the hearing officer. This person often has very warm feelings for the entity or does regular work for the entity and is compensated handsomely. Third, hearsay evidence is allowed. Opinions, and perhaps "facts" that can not be substantiated, are treated as legal fact. Fourth, there is no ability to overcome a hospital's refusal to provide supporting evidence or a comparison of habits and results of colleagues not under review. Fifth, the reasons for the hearing do not have to be specific.

In sum, one may be faced with a jury selected by one's accuser, as is the judge; prohibited access to evidence; vague charges; and a controversial opinion. No one should have trouble identifying this as a kangaroo court!

Now contrast this process with a malpractice trial. Here the judge is not selected by either party, and the jury is composed of strangers. No hearsay evidence is allowed. Both sides have a right to discovery, and subpoena powers exist. Crucially important, the charges are very specific.

Our forefathers formed the Constitution and Bill of Rights when the Inquisition was still affecting the daily lives of many. After 200 years we no longer appreciate how very important these concepts were. Exceptions now are the over 1,000 doctors who have been expelled from a medical staff. Many have been suspended for trivial reasons, such as standing on the patient's left when doing a cholecystectomy, when the chief favored the right. Surgeons who have uneventfully, and safely, done vascular procedures using techniques that include trivial differences have lost privileges. Doctors may be denied privileges because they have not done a newly selected number of cases. Of course, those determining the critical numbers often did not fulfill that requirement either. Turf is more dear day by day!

Fortunately, the federal courts are not allowing the immunity that perpetuated the Inquisition that lasted 700 years. One physician's shabby, unprincipled, and unprofessional review was exposed. Another was not forced to sign a sham contract and his "143 cases of substandard care" were found exemplary. A pathologist was not forced to give 11% of his gross income to the hospital administrator, and his colleague's false testimony was exposed. These are three examples from 400 with which we have been directly involved.

Currently, 1 in 20 physicians will undergo the peer review process. One in 5 will serve on such a committee. Contract physicians will often be asked to serve, for their contract is at risk with no peer review rights. Hospitals are using peer review as the tool to serve their business interest more and more. Ethical and excellent medical practices can be at risk.

The Semmelweis Society simply supports peer review with "clean hands." We believe the jury should be wholly comprised of outside peers. Evidence never presented during the examination is not to be considered and given weight during the deliberation phase of the hearing.This occurs when the accused is known to those sitting in judgment. The shadows raised by commonly known, but untrue, malicious gossip are hard to fight even if never identified. They should not influence the outcome. We wish written, agreed upon guidelines for practice recommendations, in contrast to *ex post facto* rules that reflect the whim of the reviewers. Our bylaws are the only shield to protect a doctor from abuses we see in over 50% of medical peer reviews. Most are based on economic concerns, not bad medicine! Bylaws may be boring but are crucial to one's well being. There should be national standard bylaws rather than differences that favor the maintenance of monopolies. We wish data-driven peer review, thus there should be access to the computer data on unidentified colleagues on the staff.

Physicians should not be second class citizens, but should have the same rights as those guaranteed by a malpractice trial. An adverse peer review often leads to progressive expulsion from all hospital staffs; a "domino" effect. This is based on an "extended liability" concept that allows a flawed peer review, at only one hospital, to be used as the sole reason for expulsion at all hospitals.

This process is expensive, averaging $100,000, that is, if one wins in the hospital! Physicians making the charge spend no money, but much time.

The profession of medicine is under attack. In the process no physician is safe from the abuse of peer review. We encourage physicians to examine their bylaws and look at our collegial behavior. Who is brave enough to stand against an opinionated chief of any department, when the bylaws give minimal rights and state laws give the accuser immunity?

We need to draw together behind the bulwarks of the Constitution, and good bylaws, in these economic hard times. Splitting into warring camps plays into the hands of the many business and economic interests attacking quality medicine and surgery.

From the Directors of the Semmelweis Society, Downey, California.
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From http://semmelweis.org/ which has more information on peer review.